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ABSTRACT

An analogy is drawn between the dynamics of interpersonal relationships and the relations of health educators to the health education profession. Recommended is the use of a 54-item questionnaire, the Fundamental Interpersonal Relationship Orientation - Behavior (FIRO-B), to determine what behavior a respondent expresses toward others and what behavior is expected from others. This introspective exercise was used to determine how those involved in health education feel about their work, how they would improve the professional status of their occupation, and what can be done to improve professionalism in health education. Assuming that each individual wishes to fulfill personal needs for inclusion, control, and affection or emotional involvement, it is suggested that low levels of professional satisfaction can be due to deficiencies in these dimensions just as interpersonal incompatability can be attributed to a lack of mutual need satisfaction. Characteristics of a profession are discussed as they relate to the satisfaction of these needs. (PBS/JD)

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THE PROFESSIONAL HEALTH EDUCATOR AND THE FIRO-B: OUR PERSON-PROFESSION RELATIONSHIP*

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* This article is based on a presentation made by the author at the annual convention of the American School Health Association in Atlanta, October 14, 1977.

Introduction

The principal objective of this article is to describe the similarities between the components of interpersonal compatibility and the quality of the health educator's person-profession relationship. The idea of conceptualizing a theory of interpersonal behavior in a person-profession context came to me in my continuing efforts to assist aspiring health educators at the undergraduate level of preparation in "professionalizing" themselves. The goal sought is the advancement of the profession via the reduction of the deficiencies that characterize professional health education.

The Interpersonal Underworld by William Schutz[1] opens with this exchange between a father and daughter.

> "Laurie was about three when one night she requested my aid in getting undressed. I was downstairs and she was upstairs, and... well.
>
> 'You know how to undress yourself,' I reminded.
>
> 'Yes,' she explained, 'but sometimes people need people anyway, even if they do know how to do things theirselves.'
>
> As I slowly lowered the newspaper a strong feeling came over me, a mixture of delight, embarrassment, and pride; delight in the realization that what I had just heard crystallized many stray thoughts on interpersonal behavior; anger because Laurie stated so effortlessly what I had been struggling with for months; and pride because, after all, she is my daughter."

This is the beginning of a book which describes and develops a three-dimensional theory of interpersonal behavior. It is designed not only to understand but also to appreciate the meaning of the phrase "people need people."

Establishing the Relationship

First of all, if you are a veteran of many years as a health educator, it is suggested that you try to recapture the thoughts and feelings you had about your profession when you were naive, a neophyte in the true sense of the word. You are asked to rate the quality of your person-profession relationship.

Go ahead... see if you can do it. On a scale of zero to ten, with zero being low and ten being high, specify a number which represents the quality of your person-profession relationship. (Please interrupt your reading and actually try to do it.)

Well, did you have any difficulty? How did you decide on a number? Perhaps you were unable to arrive at a number. If you didn't (or couldn't) select a number it may have been because you didn't know what criteria to use for a judgement. If you did determine a number it would be interesting to know what criteria you employed as your standard.

If you had been asked to identify a person you know and asked to rate (again on a scale from zero to ten) the quality of your interpersonal relationship, you could probably do so, and with very little difficulty. One reason is that there are some readily available criteria for us to use in judging the quality of our interpersonal relationships. Those criteria might include: how much time we spend together; how much mutual liking is experienced; and the extent to which we satisfy each other's social, intellectual and emotional needs. But such criteria are less clearly established for the task of assessing the quality of our person-profession relationship. It seems important to recognize that there will probably be periods of time when we experience dissatisfactions in our professional activities. Sometimes those dissatisfactions may be intense and enduring. If we had a method of identifying the sources of dissatisfaction perhaps we could minimize the frequency, strength, and duration of the affective consequences we experience. As a result, we may be able to reduce the amount of energy lost through combatting the symptoms of malcontent and instead recycle or redirect it into activities which yield personal gratification and professional benefit. What seems to be needed is a somewhat concrete framework upon which to base an understanding of the nature and quality of the relationship each of us

has with professional health education. The FIRO-B was chosen to achieve this purpose. The analogy may be a bit underdeveloped but I think it applies nonetheless.

The FIRO

FIRO is an acronym which stands for: Fundamental Interpersonal Relationship Orientation. The first of Schutz's postulates is that every individual has three interpersonal needs - inclusion, control, and affection. Each of these constitutes a range and depth of interpersonal behavior sufficient to account for the explanation and prediction of interpersonal behavior. The FIRO-B form, B meaning behavior, was selected for my purposes because it emphasizes the behavioral aspects of interpersonal relationships. Schutz defined the interpersonal needs as follows.

Inclusion - The need to establish and maintain a satisfactory relation with people with respect to interaction and association.

Control - The need to establish and maintain a satisfactory relation with people with respect to control and power.

Affection - The need to establish and maintain a satisfactory relation with others with respect to love and affection.

The FIRO-B is a fifty-four item questionnaire that assesses what behavior the respondent expresses toward others, and the behavior the respondent wants others to exhibit toward him. This questionnaire yields six scores: expressed inclusion behavior (eI), wanted inclusion behavior (wI), expressed control behavior (eC), wanted control behavior (wC), expressed affection behavior (eA), and wanted affection behavior (wA). The matching of one person's e and w scores with another person's e and w scores provides information about compatibility in their interpersonal interaction.

To Schutz, compatibility is a property of a relationship between persons, between an individual and a role, or between an individual and a task situation

that leads to mutual satisfaction of interpersonal needs and harmonious coexistence. Focusing on the role and task situation portion of this definition, it is possible to comprehend the importance of compatibility (mutual need satisfaction) in one's relationship with his/her profession.

The Transition

If one were to make studies of interpersonal relationships, it would be possible to observe that relationships sometimes achieve levels of high quality, and to observe that relationships sometimes deteriorate to the point of termination. The ups and downs could probably be explained (at least partially) through a careful examination of compatibility on the dimensions of inclusion, control, and affection. The reader is now requested to shift his/her attention from interpersonal behavior to the person-profession relationship.

Which of the following alternatives best represents your response to this question: Do you think that health education has achieved "professional" status?

a. "Yes, of course we have. I resent any implication that we haven't."
b. "Well ... yes; I think so."
c. "Not yet, but we're almost there."
d. "No, definitely not."

Have you decided which response is the most defensible? Regardless of the choice you made, you must have had certain criteria in mind. The characteristics which appear in the list below often emerge as indicators of the degree to which an occupation is professionalized.

1. A profession renders a unique and essential service.
2. A profession has high standards for the selection of its members.
3. A profession requires extensive preparation of its members.
4. A profession has established a theoretical base which underlies its practice.
5. A profession has developed a self-regulatory control system.
6. A profession has generated recognition from and approval by other groups.
7. A profession is representative of its membership via an official association.

In 1974, a study was made of the perceptions of selected members of the

New York State Federation of Professional Health Educators regarding health education as a profession. NYSFPHE was described as an alliance of professional health educators which has as one of its goals furthering the professional status of the field. Selected members were asked to indicate their support for or opposition to certain activities related to professionalization. It seemed reasonable to assume that if members perceive that their occupational group lacks certain of the attributes of a profession, they would support activities enabling the acquisition of those characteristics which are perceived to be lacking. However, data analysis suggests that respondents' support for actions was not based on perceived needs in health education.[2] If practitioners do not strongly support activities which would enable the acquisition of characteristics not present, or only moderately present, then it seems that we either fail to understand the process of professionalization or that we have chosen not to actively facilitate it. This is not so difficult to comprehend, I suppose, if you consider that most of us probably invest more time in the participation of those activities that we perform well as compared with those activities that we do less well. Understanding the situation is one thing, rectifying the situation is quite another. If we perceive professional health education to possess deficiencies, it behooves us to engage in those activities that would allow us to overcome those deficiencies and attain the attributes required for genuine professional status.

Perhaps if we return to the FIRO for an illustration the point might be made more clearly. Two people might recognize that they experience moderate compatibility on the inclusion dimension but low compatibility on the control and affection dimensions. If they make no attempt to improve in the control and affection areas of their relationship, the deficiencies will undoubtedly persist and the overall level of mutual need satisfaction will continue to be

low. Similarly, it might be reasonable to conclude that progress toward enhancing professional health education will be slow unless major efforts are made to acquire the attributes which are not now found to distinguish us as a professional group.

A closer examination of those characteristics of a profession is useful for identifying areas which might account for personal feelings of dissatisfaction with our profession.

1. A profession renders a unique and essential service.

Evidence that we have failed to define our uniqueness is abundant. For example, Simonds writes ... "A fundamental obstacle to collecting accurate and comparable data on health education manpower is an acceptable definition of the occupational category and the professional health educator. As an occupational speciality health education falls within category No. 171 of the U.S. Census, in a group with social and welfare workers. However, the Carnegie Commission on Higher Education has grouped health education specialists among the 'high level' health care jobs (along with psychiatrists, neurologists ...)"[3]

One of the purposes of a study by Shirreffs was to identify whether a consensus existed among college and university health educators (N=603) on the mission or goals of health science/health education. Sixty percent agreement was established as indicative of consensus. The mission receiving the highest agreement was "to foster positive health attitudes and value development in individuals" (36% of the respondents agreeing). The mission receiving the next highest percentage of agreement (32%) was "to change behaviors and practices that detract from health to those which promote health in individuals." One of Shirreff's conclusions was that the discipline needs to develop a professional identity, based upon common goals, policies and parameters.[4]

Evidence such as this attests to the existence of a considerable degree of fragmentation concerning professional health education's uniqueness. Other indicators of "diffusion" in this regard can easily be found. A recent Task Force Report reviewing current programs, practices and major problems stated that "if health education is to survive as a profession, rather than just a movement, or a philosophy of life, it must acquire more precise discipline, This, in turn, calls for more precise definition, of both goals and methodology." Arguing that such issues are not just academic, the authors contend that the problem represents one reason for the vast discrepancy between the lofty goals frequently advanced by advocates of health education and the limited achievements actually experienced.[5]

2. A profession has high standards for the selection of its members.

One of the weaknesses of professional health education in the past has been our tendency to allow people to enter the ranks of health education practice primarily on the grounds that they were interested in health education. Consequently we have a variety of people with sometimes dubious credentials practicing health education. It is not uncommon to find practitioners whose professional preparation and/or experiences are predominately in the areas other than health education. "Pure-bred" professional health educators have only recently appeared on the scene, and although much progress is being made in this area it is still possible at a number of degree-granting institutions to enter professional health education at the masters level without prerequisite coursework or academic field experiences.

3. A profession requires extensive preparation of its members.

Several important efforts have been made to satisfy this criterion. Each of three professional associations has held conferences and published guidelines pertaining to the professional preparation of entry level practitioners.[6,7,8]

More recently, the purposes of a workshop commonly known as the Orkand Conference were: a) to enable practitioners of community, patient and school health education to exchange views on the commonalities and differences in preparation and practice, and b) to explore the potential for fashioning acceptable guidelines for professional preparation and practice that will include all of the health education settings.[9] It should be noted, however, that one can become employed in school health education positions without extensive preparation. State departments of education/public instruction still "certify" people who do not possess the qualifications which are considered minimal by those who conduct professional preparation programs in health education at colleges and universities. In fact, even that which is considered minimal is a matter of some debate. These statements from an article by Ware provide an example. "While there may be little disagreement with the many definitions of health education, there is much to be unhappy with in the definition of a professionally trained health educator. Performance expectations are vague. They do not clearly define in any detail competencies and skills. It is not so much that profe sionally trained health educators do many things under many titles that is of concern here, but rather that we at least agree for sure that there is a common core from which we start."[10]

4. A profession has established a theoretical base which underlies its practice.

Professional health education research is young and relatively unsophisticated. We have probably invested more time in the conduct of survey research and curriculum development than in any other activities. It seems fair to say that a theoretical base is just beginning to emerge, and that it has yet to be adequately tested. The most rigorous research tends to be done by social-psychologists investigating those areas of human behavior which pertain to health problems. A number of professional publications contain research progress reports

on the well-known Health Belief Model but professional health educators have made only limited headway toward generating their own "body of knowledge." In his address at the Annual Meeting of the American School Health Association in Atlanta in 1977, S. Simonds indicated that, with the exception of the so-called Health Belief Model, "there had been virtually no research in health education developed in a programatic way over a period of time so as to afford a systematic way of dealing with the many variables" which influence health-related behaviors.[11]

5. A profession has developed a self-regulatory control system.

Professional health education lacks the unification required to prepare, adopt, and implement a set of procedures for credentialing its practitioners and for governing their professional behavior. Efforts have been made to address these issues. The Orkand workshop was initiated, at least in part, by the recognition of variation in the preparation of professional health educators, and by the realization that a more uniform system of preparation might be a positive step toward credentialing. Regarding sanctions to regulate the behavior of health education specialists, the SOPHE Task Force on Ethics prepared a set of preamble items and principles in 1976. It is not known whether the practices of the majority of professional health educators are consistent with the principles in the code.

6. A profession has generated recognition by and approval from other groups.

There is legislation (PL 94-317, National Consumer Health Information and Health Promotion Act of 1976) and there are policy or position statements from the American Medical Association, the American Academy of Pediatrics, The American Hospital Association, the National Education Association and others which, at least in a rhetorical sense, support the need for systematic and comprehensive education about health. But the legislation and position papers rarely, if ever,

specify that the practitioners conducting these programs are to be health education specialists.

Two brief examples of the obscurity of health education specialists can be cited from my own experience. The first illustration originated in a meeting with a cardiologist on the faculty of a university medical center. I had requested his assistance as a consultant for a study I was beginning. When we first met I introduced myself as a health educator and his reply was ... "What the hell is a health educator?" The second example involves a pediatrician as a guest speaker in a course I was conducting titled Elementary School Health. During our class I asked the doctor what he thought health education specialists could contribute to the healthfulness of school children. His reply was also interesting. He said, "I'm not too worried about health educators doing harm ..." (Did you ever feel like you were on a treadmill, working hard, but never seeming to make any progress?)

It is entirely possible that professional health education enjoys more support from the people receiving its programs than it does from physicians who often ignore us, school boards which slash our budgets, state education departments which won't enforce mandates, and so on.

7. A profession is representative of its membership via an official association.

At first glance it appears that professional health education is stronger on this characteristic than on any of the other attributes. The reason? We are represented by numerous professional groups: the Association for the Advancement of Health Education, the American College Health Association, School and Public Health Education Sections of the American Public Health Association, the Society for Public Health Education, the Society of State and Territorial Directors of HPER,etc. However, a careful analysis of professional representation reveals that fragmentation and competition may be inhibiting the unification which some

consider to be so seriously lacking among professional health educators. The introduction of a background paper for the Orkand workshop indicated that one of its purposes was to explore the potential of a coordinated, acceptable approach among all the various organizations associated with the field, and to define their common ground ... the philosophy, functions and preparation that are the essence of a professionally trained health educator.[12] This challenge was not a new one. Hoyman raised the issue more than twelve years ago. 'Do we really need completely separate national organizations, or would one unified association be more effective?'[13]

Returning to the Premise

An attempt has been made to draw an analogy between the dynamics of interpersonal relationships and a somewhat unfamiliar concept: that of a person-profession relationship. It is suggested that a measure of our compatibility with the health education profession can be found in:

1. the degree to which we are included in the activities of the profession;
2. the degree to which we are able to exert an influence upon the rate and direction of our professional evolution; and
3. the degree to which we manifest emotional involvement with professional health education's purposes and processes.

It is conceivable that low levels of professional "satisfaction" could be explained by the presence of deficiencies on these dimensions just as interpersonal incompatibility can be attributed to a lack of mutual need satisfaction considering the same factors of inclusion, control and affection. I wish there were devices by which we could quickly and accurately evaluate our professional blood pressure and heart rate, but I suppose that for now we must rely on other indicators. Perhaps if we would pause periodically to assess the nature and quality of our person-profession relationship, we could become

more sensitive to the early signs of under-inclusion, abdicated responsibility for control, and emotional withdrawal from our professional endeavors. Unless we recognize that we fail to fully demonstrate some of the attributes which characterize a profession we cannot move forward to remove the deficiencies and enhance not only our profession but the quality of our relationship with it. These are the conceptual applications that I think the FIRO-B has to offer us for our journey toward elevated professionalism in health education.

REFERENCES

1. Schutz, W, The Interpersonal Underworld, Palo Alto: Science and Behavior Books, 1966.

2. Taub, A, "A study of health education as a profession: perceptions of selected members of the New York State Federation of Professional Health Educators," Xerox University Microfilms, (New York University Ed.D., 1975)

3. Simonds, S, "Health education manpower in the United States," Health Education Monographs, 4(3):208-225, 1976.

4. Shirreffs, J, "A survey of the health science discipline and its relationship to other academic disciplines," Presented at the annual convention of the American School Health Association, October, 1977.

5. Task Force Report, "Health Promotion and Consumer Health Education," Preventive Medicine - USA, New York: Prodist, 1976.

6. American Assoication for Health, Physical Education and Recreation, Professional Preparation in Safety Education and School Health Education, Washington: AAHPER, 1974.

7. ASHA Committee on Professional Preparation, "Professional preparation of the health educator, "Journal of School Health, 46(7): 418-421, 1976.

8. SOPHE Ad Hoc Task Force on Professional Preparation and Practice of Health Educators, "Guidelines for the preparation and practice of professional health educators," Health Education Monographs, 5(1):75-89, 1977.

9. Preparation and Practice of Community, Patient, and School Health Educators: Workshop on Commonalities and Differences, Orkand Corporation, Bethesda, February 15-17, 1978.

10. Ware, B, "Directions for health education: new spokes in the wheel... or a new wheel?" Health Education Monographs, 4(3):247-253, 1976.

11. Simonds, S, "Health education today: issues and challenges," Journal of School Health, 47(10):584-593, 1977.

12. Ware, B et al. "A new and accurate mappe of the world of health education drawne according to the latest discoveries - 1978," Preparation and Practice of Community, Patient, and School Health Educators: Workshop on Commonalities and Differences, Orkand Corporation, Bethesda, Feb. 15-17, 1978.

13. Hoyman, H, "Bottlenecks in health education," American Journal of Public Health, 56(6):957-960, 1966.